	Project Group: Provider Practice Workgroup Leader		
	Goal:The proportion of patients receiving care consistent with evidence based standards will increase. **75% of PCP's in the state will adhere to diabetic evidence based care standards, and will use Vermont Health Record or its equivalent (by 2010).**		
	High Level Objectives	1. By 2010 increase to 75% the proportion of individuals with diabetes in care whose HbA1c <7 and to 70% for LDL < 100. (D1.1)	
		2) By 2010 ensure that 75% of PCP's are using the Vermont Health Record or a tool with equivalent functionality for proactive individual and population based care management. (D1.2)	
		3) By 2010 increase to 95% the proportion of individuals with diabetes in care who report 2 or more HbA1c tests in past 12 months (D1.3)	
		4) By 2010 the Blueprint Chronic Care Initiative will be inclusive of no fewer than four chronic conditions and will adopt clinical practice guidelines for these chosen conditions	
		5) By 2010 increase to 93% the proportion of individuals with diabetes in care who report having a dialeted eye exam within the past 12 months. (D1.4)	
		6) By 2010 incease to 73% the proportion of individueals with diabetes in care who report having had an influenza immunization within the past 12 months. (D1.5)	
		7) Progressive rollout of Microsystems statewide to address barriers and facilitate change efforts by providers	
		8) Develop provider communication strategy for Blueprint/CCM engagement and for communicating progress on implementation	
	Data Sources	BRFSS, registry and claims data to evaluate compliance with goal, HEDIS, HSA discharge and lab data	
	Prioritized Activities	indicators of improvement for LDL and HgbA1C (D1.1)	
	for year 1	2. Determine communication plan needed to recruit providers/practices	
		3. Propose incentives available to providers - consult with Health system workgroup	
		4. Identify non financial barriers and develop strategy to resolve barriers and engage providers	
		5.Approval of educational approach and evaluation of providers and staff re: Chronic Care Model and model for improvement (microsystems)	
		6. Oversite and approval of data points and functionality re:Blueprint CCIS ie. Vermont Health Record (registry)	
		7. Evaluate content and effectiveness of paper copy for manual data entry of patient information into database by pilot sites	
		8. Approve evaluation tool to be used for providers and pilot communities	

High Level Objectives	Objectives/ Milestones	Activities	Who Responsible	Start Date	Due Date	Status	State Measures/ Outputs	Pilot Measures/ Outputs	Notes	Comment
D1.2	Determine pilot sites and percentage of providers to implement plan	Define criteria for selection	Steering Committee/ Workgrp. Leaders	Dec-05	Feb-05	Done	Communities selected		St. Johnsbury and Bennington, 75% of PCP's will be using framework and registry by end of 2006	
	Develop plan to implement CCM and diabetic registry	Determine number of PCP offices in each pilot site	PHO-SW Ruggles-NVRH	Jun-05	Sep-05	Done	Develop spreadsheet of all PCP practices and names of all providers per practice in all HSA's			
		Define responsibilities and comment for participation	Pilot Sites and Prov. Prac. Workgrp./ Strategic Plan	Jun-05		Done	Criteria for particiapation will be developed and agreed upon		Registry use, referral to self mgmt, community engagement	
		Develop agreements between grantees and providers		Aug-05		In Process	Develop agreement form. Providers will understand participation requirements and will sign agreement form	75% of PCP's will sign participation agreement	Financial support based on signed agreement	Cosistency will be maintained by using one form for all sites
		Collect baseline data from providers	PHO-SW Ruggles-NVRH/ VHR	Nov-05			Evaluation of process and clinical measures			
		Determine number of PCP offices able to use registry (i.e.. not doing VDIS study)	PHO-SW Ruggles-NVRH	Jun-05	Sep-05	Done	Determine end date for VDIS study, phase plan for inclusion of all providers	75% of providers able to participate	Can still educate VDIS group and collaborative group to self mgmt. and community programs Other - microsystem, ICIC	

High Level Objectives	Objectives/ Milestones	Activities	Who Responsible	Start Date	Due Date	Status	State Measures/ Outputs	Pilot Measures/ Outputs	Notes	Comment
	Develop provider engagement and recruitment strategy for each HSA	Determine communication needed for provider engagement and recruit providers/ practices	Executive Director/ Workgrp leader	Apr-05	Dec-05	62% Ben., ?# St.J.	Materials, plans, and options for recruiting providers will be developed and shared with HSA's 75% of PCP's will be recruited and agreement signed statewide	75% of PCP will be recruited and agreements signed in pilot areas	Statewide communication plan for blueprint, then consistent information for communities re: support, incentives ect.	
		Assess financial and non financial barriers	Prov. Prac wrkgrp			Done	Barriers will be identified statewide		Based on work flow of individual practice.	Microsystem

High Level Objectives	Objectives/ Milestones	Activities	Who Responsible	Start Date	Due Date	Status	State Measures/ Outputs	Pilot Measures/ Outputs	Notes	Comment
		Develop strategy to resolve non financial barriers and engage providers ie education, IT	contracted vendors/ Exec. Director				All elements of the CCM are operational.	All elements of the CCM are operational.	Use of microsystems, QIO, and IT	
		Identify Shorterm (Blueprint) incentives available to providers	Exec. Comm.	Jan-05	Annually 7/2005	done (pilot fisc. 06)	Incentives agreed to, communicated, and grants implemented	Incentives agreed to, communicated, and implemented, evaluate change of oucomes re: incentives behavior change	1) nonpractice staff time, i.e.. data entry 2) Money- a) blueprint,	
		Identify Longterm (systems improvement) incentives available to providers	Health Sys Workgroup/ VPQHC	Oct-05	tbd	In Process	Framework and metrics identified and implemented	Framework and metrics implemented	1) insurances	
	Develop rollout plan for bringing on providers in new HSA's	Decide phasing of provider offices with timeline	Project Mgr and Workgroup						Hospital service areas, PCP's, and specialties	Must evaluate before spread!
		Decide what practices will use computer registry vs. paper copy	Project Mgr./Pilot Communities				Phased plan for using registry will be developed		This will be decided using input from IT of what they can have the form look like	
	Develop plan for non-computerized patient registry sheet	Determine look and content of paper copy	Provider Workgroup recommends to IT/ Pilot communities				Paper copy will be available for use in communities	Pilot communities will trial paper copy	? Print screen,	Will need initially in pilot practices before spread!

High Level Objectives	Objectives/ Milestones	Activities	Who Responsible	Start Date	Due Date	Status	State Measures/ Outputs	Pilot Measures/ Outputs	Notes	Comment
		Decide system for entering into computer and patient chart	Pilot sites will decide					Plan developed to enter initial data and to keep registry updated	NCR paper etc., data entry. Must meet medical record requirements (no loose sheets, think of thickness of paper)	
	Interface with IT regarding Registry	Identify needed features for each new clinical condition	Prov. Prac/ VPQHC/ QIO/ Health Sys. Wrkgrp	Feb-05	Annually January	done fisc. 06	Criteria will be developed as to which data sets are used for reporting requirements (ie clinical and financial)		HEDIS, CMS/DOQIT, P4P	

High Level Objectives	Objectives/ Milestones	Activities	Who Responsible	Start Date	Due Date	Status	State Measures/ Outputs	Pilot Measures/ Outputs	Notes	Comment
		Oversee education plans for providers and staff re: registry	VPQ				By 2010 the VHR or a tool with equivalent functionality is operational in 75% or more PCP's	75% of PCP's using a diabetic registry in pilot sites		
D1.1 D1.3 D1.4 D1.5		Approve education plans for providers and staff re: Chronic Care Model and model for change	Prov. Prac. Wrkgrp. VPQ/ICIC, web material		Dec 05 Annually Oct		75% of providers following CCM and evidence based guidelines statewide starting with diabetes	75% of providers following CCM and diabetic evidence based guidelines in pilot sites	Review National Diabetic Guidelines/ update as needed Determine criteria to evaluate this, Data from VHR	
		Approve education plans for providers and staff re: Healthier Living Workshop and resources available	Self Mgmt/Prov. Prac	Sep-05	Dec-05		50% of patients referred and participation starting with diabetes	% of patients referred and participation	Data downloaded from Healthier Living database	
		Approve education plans for providers and staff re: referral form	Robin Edelman/ Self Mgmnt/ Prov. Prac..	Sep-05	Dec-05		50% of patients referred and participation			
	Development of goal ranges for LDL and HgbA1C	Review HEDIS local and state baseline		Dec. 05			Develop goal ranges for baseline implementation of state guidelines			

High Level Objectives	Objectives/ Milestones	Activities	Who Responsible	Start Date	Due Date	Status	State Measures/ Outputs	Pilot Measures/ Outputs	Notes	Comment
D1.1 D1.3 D1.4 D1.5	Approval of educational approach and evaluation of providers and staff re: Chronic Care Model and model for improvement (microsystems)	Approve educational plans for providers re: clinical guidelines with evidence based practice starting with diabetes	VPQHC,QIO/ Microsystems	Feb-05	Dec 05 Annually Oct	In Process	95% of pts. with diabetes in care report 2 or more Hgb A1C tests in past 12mos., 93% report having a dialated Eye exam Q12 mos., 73% influenza immunization Q 12 mos., and Hgb A1C and LDL levels will meet goal range by 2010. BP to meet goal of 130/80. Reduce hospital discharges for diabetes by 5% by 2010,	Hgb A1C Q6mos., Eye exam Q12 mos.,Influenza immunization Q 12 mos. and % Hgb A1C achieving >10% reduction in 3 months and LDL levels will meet goal range. BP to meet goal of 130/80. Reduce ED visits by ??? Baseline required Reduce hospital discharges for diabetes by 5%	Incorporate pay for performance into clinical measures and incentives	

High Level Objectives	Objectives/ Milestones	Activities	Who Responsible	Start Date	Due Date	Status	State Measures/ Outputs	Pilot Measures/ Outputs	Notes	Comment
		Approve education plans for providers and staff re: community resources available	Community Workgroup Leaders/ Local teams				% of patients referred into nutrition and physical activity programs, % of pts.who accomplished participation	% of patients referred into nutrition and physical activity programs, % of pts.who accomplished participation in pilot areas	Review % by Prov. Prac. Workgroup	
		Approve alternative educational approaches	VPQHC or other vendor contract	Jun-05	Annually Oct				Want all components of education available, experts for each component during 4 hour education program	Need to evaluate how it has worked and needs of practices trying to reach.
	Evaluate implementation	Develop and approve process evaluation tool to be used for providers and staff	All Workgroups /Executive Director				Evaluation tool developed with input from all groups		focus group, survey,	
		Agree to tool and questions to be used		Nov-05					One tool to be used by all work groups, provider group to approve their part	
		Review clinical data		Jun-05			Data reviewed and recommendations made for future rollout		Data to be provided for evaluation	
	Revise implementation plan as needed	Review analysis of process evaluation and develop recommendations for improvement	Workgroup with Project Manager	Feb-05	Jun-06		Recommended changes for implementation among all HSA's developed			

High Level Objectives	Objectives/ Milestones	Activities	Who Responsible	Start Date	Due Date	Status	State Measures/ Outputs	Pilot Measures/ Outputs	Notes	Comment
	Decide on phasing plan for next clinical condition and selection of evidence based clinical guidelines to be used	Decide which conditions will be implemented for years 2-5	Prov. Prac./ Health Syst. Wrkgrp	Jan-06			No fewer than four chronic conditions with clinical practice guidelines will be implemented by 2010	No fewer than four chronic conditions with clinical practice guidelines will be implemented by 2010	In consultation with Health System group	
	Develop plan to replicate throughout state	Identify tools needed	Proj Mgr				Tools and materials will be available to share			
		Identify communication route	Workgroups							
	Recommend/ Develop Communication strategy	Develop Communication strategy for providers	Exec. Committee/ Prov. Prac.	Sep-05	Dec-05				Communication of Blueprint to all providers	